Q#	Question	Answer	RFQ Amendment
1.	We are curious about the steps that will be taken to ensure that no unfair advantage accrues to responders to Phase II of the procurement process (the RFP), if one is needed. The specific issue is potential bidders' access to the RFQ. If bidders have access to the RFQ, it seems to us that this would constitute at least four months of additional preparation time that is not available to the RSNs. We realize that bidders for the RFP have a potentially shorter response time than for the RFQ, but it is certainly not equal to four months. We also realize that the RFQ and the RFP may differ in some respects, but the fact that they both must address business fundamentals suggests that they may not differ enough to offset the advantage.	The RFQ is a public document and available to everyone on the same date, so it is not correct that potential responders to the RFP would have the RFQ information available any longer than the RSNs.	
2.	May the RSN delegate/subcontract Authorization and Utilization Management functions to an independent Administrative Services Organization (ASO)? The ASO is independent from the provider network	Yes, The RFQ is amended to read: Authorization and utilization may not be delegated to a network CMHA. Additional language is added to require a delegation plan if these functions are delegated. This does not restrict delegation to an ASO.	Yes
3.	May the RSN delegate/subcontract Care Management functions to an independent Administrative Services Organization (ASO)? The ASO is independent from the provider network	Yes, Section 3.4.17.1 states these functions may not be delegated to a network CMHA. It is does not restrict using an entity that is not a CMHA from being delegated care management.	
4.	Do these two citations (3.4.23 and 3.4.17.) literally mean what they say, that is, the RSN may not delegate/subcontract these functions to any entity, including an independent ASO?	See the response to questions 2 and 3.	
5.	The RFQ mentions answering the "Requirements", which are sometimes different than the "Questions." Which are we supposed to be answering, so we can format our responses appropriately?	For each Requirements section and its corresponding Questions section: Step 1 – Restate the entire Requirements section Step 2 – Restate each individual Question in the corresponding Questions section. Step 3 – Answer each individual Question. Repeat 2 & 3 until all questions are answered Step 4 – Insert a page break after each Requirement and Question Section Step 5 – Insert attachments clearly labeled with the corresponding Question. See the answer to question 188 for an alternative for submission of attachments.	

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		Step 6 – Insert a page break after the attachments. For the electronic copy: Each Requirements section must be in a separate folder, including all Requirements documents and all Questions documents. Attachments must be in the folder and be named in a manner that corresponds to the Question number or Questions numbers they pertain to. If attachments address more than one Requirement they must be duplicated in each folder and named in accord with the Question(s) for that Requirement.	
6.	3.2.11, "Management Attestation Requirements" refers to the "RSN's CEO". Is this the RSN Administrator?	The CEO is the individual the RSN designates as the RSN's chief executive.	
7.	3.4.22.5,6 refers to the RSN's clinical staff and emergency calls to the RSN. Is this referring to providers and their clinical staff that do our crisis work?	No, this refers to the RSN staff.	
8.	If an RSN meets all other standards but the Administrator position is in transition – during the time of the response to the RFQ – would this disqualify an RSN from being qualified?	No	
9.	I am requesting directions for the RFQ Pre-Response Conference meeting. The meeting is scheduled from nine – noon on Wednesday, October 19, 2005 at the OB2 – Lookout conference Room in Olympia.	Directions were posted on the Procurement Website.	
10.	Can you tell us what constitutes a zero vs. a 5 on the MSR items?	0 is defined as non-responsive 5 is the maximum possible score for any section.	
11.	Will evaluation teams score particular Sections of the RFQ for every RSN, or, will separate evaluation teams be assigned to evaluate each RSN's entire RFQ response?	The RFQ evaluation teams will each be assigned a section of the RFQ to evaluate. Teams will evaluate that section for all responses received.	
12.	We have contracted with Volunteers of America to provide our crisis line-telephone services only to triage and dispatch crisis workers from other providers in our network. They do not provide any face to face services. Would they be considered a CMHA as defined in the RFQ?	CMHA is defined in RFQ section 1.9. Whether an entity is a CMHA in the RSN's network depends on the contractual relationship between the RSN and that entity. Crisis line is a direct service support activity. If an organization is providing only this service the organization is not a network CMHA. See answer to question 152.	
13.	In 3.4.23.1 the RFQ states that Authorization and utilization management shall be provided by the RSN, these functions may not be delegated. In 3.4.2.4 "Provide written policies and procedures which have been formally adopted by the RSN, that address how the RSN	See the response to questions 2 and 3. Authorization, Utilization and Care Management, may be delegated, but not to a network CMHA.	

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	will authorize services following an intake based on medical necessity and the Access to Care Standards, how enrollees denied an intake evaluation will receive a Notice of Action form from the PIHP or its formal designee...." 3.4.12.7 states that "Customer Services must not be delegated to a provider of services" 3.4.17.1 states that Care Management functions are distinct from case management services and may not be delegated to a network CMHA." 3.4.17.2.5 Utilization management including review of requested services against medical necessity criteria, authorization of necessary care, and ....." We are very confused as to what may be delegated and to whom. Please clarify.	Customer services cannot be delegated to a network service provider. Policies and Procedures for all required functions must be in writing and formally adopted by the RSN.	
14.	Why is MAA shifting the inpatient billings to the RSN's Does this make sense when you look at the economy of scale MAA provides vs. 14 RSN's? (Note MAA 7 billion bi-annual budget.) How much funding will be transferred to the RSN's from MAA to cover this shift?	DSHS received several questions on this topic making it clear that there are many things to consider prior to making this change. For that reason, RFQ questions 3.4.2.6 and 3.4.4.4., which address the requirement for a plan to address the transfer of inpatient billings to the RSNs are deleted. A separate Requirement and Question section is added to the RFQ. See new section 3.6 in the RFQ. RSNs are required to respond to the question. Responses submitted will be considered satisfactory for meeting the requirements of the section.	Yes
15.	4-3.2.6 "The RSN shall submit financial Statements in accordance with General Accepted Accounting Principals (GAAP).Since most of the agencies are government and follow the GASB protocols. Can we submit our financial statement reported on a GASB basis?	Yes.	
16.	1.7.23 ""In-Residence Census" (IRC) gives and exception for Consumers who are committed to the State hospital under RCW 10.77...." There should also be an exception for WMIP enrollees who are hospitalized. Please advise.	The definition in the RFQ is the commonly understood definition. In answering the questions related to IRC, the RSN should state the RSN's assumptions and tailor the response to those assumptions.	
17.	"The RSN must recruit consumers and family members as certified peer counselors or to provide other services." Our understanding was that peer counselors had to be employed by CMHAs? Please clarify.	The RSN is responsible for the recruitment and maintenance of an adequate network, including peer counselors. The modality of peer counseling must be provided by or under contract with a CMHA.	
18.	How will the Medicaid Penetration rate be calculated?	Medicaid Penetration will be calculated monthly. Medicaid Penetration = Number of Medicaid Served divided by the	

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		Number of Medicaid Eligibles.	
19.	Please define delegation.	To assign a responsibility of the RSN to another entity.	
20.	Regarding 3.1.7.1: Do all nine of the evidence-based practices have to be implemented by each RSN? Some of these do not appear to be directed at RSNs such as Multi-Dimensional Treatment Foster Care.	No. The RFQ does not require the listed EBPs be in place. The RFQ does require that the RSN have policies and procedures describing how they will increase access to identified EBPs.	
21.	What is the reason for the due date of responses to the RFQ being changed from December 15th to December 1st?	The due date was not final until the RFQ was published.	
22.	Will audits performed by the Washington State Auditor meet the requirement in 3.2.6.: *"Annual audited financial Statement shall be audited in accordance with Generally Accepted Auditing Standards by an independent Certified Public Accountant (CPA)"*?	Audits performed by the State Auditors Office (SAO) are independent audits. An SAO audit satisfies the requirement if it separately assesses the financial status of the RSN.	
23.	Regarding 3.2.6: If a state-performed audit included a RSN as an entity in a county audit (but did not include a separate RSN audit) is this acceptable to meet the requirement?	A State Auditor's Office audit satisfies the requirement if it separately assesses the financial status of the RSN.	
24.	Regarding 3.4.16.8: How should RSNs adjust for inaccuracies in the state membership files? This is particularly a concern when the membership file reflects a much larger enrollment number than the RSN is actually reimbursed for. Won't this invalidate the GeoAccess results?	The RFQ requirement and question is to assess the RSN's ability to use the data provided (or developed on their own) to measure network access. State the RSN's assumptions and describe how variances in the data are managed. The variances in the data available do not invalidate the purpose of geo-access analysis. The purpose of the geo- access analysis is to give an overview of the adequacy of the network.	
25.	The clarification on 3.4.23.1, the attached contract for September 2006 continues to state that these functions may not be delegated at all. Does the clarification provided for 3.4.23.1 apply to the contract as well?	The contracts are amended to be consistent with the amended RFQ.	Yes
26.	On page 14 of the RFQ under 2.11.2, is the intent that responses to the RFQ restate each question and begin the answer on the same page as the question and then put a page break at the end of each question response before restating the next question on the following page? In the format that was just sent out, two questions were copied prior to the body of the answer.	See answer to question 5.	
27.	Question 3.4.4.4 on page 65 of the RFQ and question 3.4.2.6 on page 54 are identical. Should one be deleted?	They are identical questions - one is in relation to State Funded services and the other is related to Medicaid funded services.	

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		Delete neither.	
28.	Will the RSNs receive the full inpatient capitation rate beginning September 1, 2006, if the RSNs become responsible for payment of community hospitals on that date?	See answer to question 14.	
29.	How will the state resolve the existing claims lag and transition between the state claims and an RSN claims system on September 1, 2006?	See answer to question 14.	
30.	Section 3.4.29.3.1 sets forth a standard performance expectation for Medicaid penetration rate. How will this be measured? Monthly? Annually?	See answer to question 18.	
31.	3.4.30.10 does not make any sense as written. Please clarify.	This RFQ Question will be amended to the following: Describe how the RSN monitors clinical outcomes and utilizes results to measure program effectiveness.	Yes
32.	The RFQ requires a GEOACCESS study. In order to accomplish this, we need to know who our eligibles are. It is obvious we will be judged non-responsive it we do not respond to the GeoAccess requirement, yet due to lack of good data from the state, we cannot respond.	See answer to question 24.	
33.	Section 3.4.17.2.4 of the RFQ states that authorizations for inpatient care must occur within 2 hours of the request. The current standard is that authorizations must occur within 12 hours of the request. Is this a typo?	Yes, 12 hours is correct. The RFQ section 3.4.17.2.4 is amended.	Yes
34.	What possible benefit is there to DSHS, the Mentally Ill, or the citizens of Washington to have PIHPs contract directly with every hospital in the state for inpatient psychiatric services? This will double the costs of inpatient care, decrease access to outpatient care, and significantly increase the costs of administration. What was the thought behind including this in the RFQ?	See answer to question 14.	
35.	On page 15, section 2.5, the RFQ states that successful RSNs will be expected to sign contracts with DSHS that are modeled after the exhibits. The model contracts are stamped DRAFT, for Internal	RFQ section 2.5 states: The Apparently Successful RSNs will be expected to sign contracts with DSHS that are substantially the same as the	

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	Discussion Purposes Only. How close to final are these draft contracts?	sample contracts for the PIHP and State shown in EXHIBIT B AND EXHIBIT C. The terms of the contract are not subject to negotiation.	
36.	Also on page 15, section 2.5, the second paragraph states that any contracts are tentatively scheduled to begin September 1, 2006. It does not state an ending date. It also states that DSHS reserves the right to extend the contracts for up to 2 years. What happens at the end of the two year extension period? Will there be another competitive procurement?	The initial contract period will be September 1, 2006 through June 30, 2007 as directed in statute. Decisions about future procurements have not been made.	
37.	On page 22, section 2.19.5. We are interested in knowing who exactly will make up the designated evaluation teams. How large will they be?	DSHS is not releasing the names of evaluators and composition of evaluation teams.	
38.	On page 38, section 3.2.6. Our RSN is operated by a County, which handles all the financial operations of the Region. Will the audited financial statements of the county performed by the State Auditor be an acceptable for response to this section?	See answer to question 22.	
39.	On page 39, section 3.2.8.3. How does one submit evidence of all internal controls? Are the state auditor audits of the county sufficient evidence of internal controls?	The RSN must identify and describe internal controls. The audit from the State Auditor is not sufficient unless it contains a detailed description and review of internal controls.	
40.	Please email us the link to the RFQ web site which posts questions and answers.	Link sent: www1.dshs.wa.gov/msa/ccs	
41.	Because the RFQ has been released on the MHD Internet site and includes both the model PIHP and state-funded contracts, bidders responding to the RFP could technically have at least four months of additional preparation time that is not available to the RSNs. How will DSHS assure that no unfair advantage accrues if an RFP is issued?	See answer to question 1.	
42.	Section 2.11 Response Preparation Requirements Subsection 2.11.2 states that RSNs should "…reiterate the number and text of the requirement in sequence and [provide] answers following each requirement."	See answer to question 5.	

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	Are RSNs to answer the requirements for each section, or answer the questions listed in that section? An example is 3.2.25 Sentinel Events and Negative Media Coverage. There are four requirements and two questions. The questions do not specifically state that each requirement must be addressed. Subsection 2.11.2 also states "… each answer should start on the same page as the requirement and should be followed by a page break". Some questions have multiple parts, for example, subsection 3.2.4.2 "Describe the RSNs organizational structure…", which has six specific subdivisions to the question. Should each subdivision be started on a new page, or just the main subsection, with the subdivisions subsumed underneath?		
43.	Section 2.12 Response Submission Format 2.12 states that "The paper copy of the response must be on standard eight and one-half by eleven inch…white paper. A font size not less than 12 points must be used. Does this apply to attached documents, such as organizational charts, maps, and financial forms? Reducing the paper size or enlarging the font may make them unreadable. In addition, 2.12 states "Responses to each question or request for information in the response must appear in the order presented. Should this be interpreted as attaching additional documents, such as policies and procedures or other documentation supporting the response, directly after the written response to the question as opposed to the end of each section, or as an appendix to the whole response	Documents prepared as part of the response must follow the required format. Documents created prior or for another purpose can be submitted in their original format as long as they are legible. See answer to Question 5.	

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	document? With regard to the format for the letter of submittal, would you prefer an actual letter format that covers the required elements, or would you prefer each called out by requirement number consistent with the format we will use for the rest of the response?		
44.	Section 2.17 Proprietary Information/Public Disclosure The second paragraph of this section states that "It is DSHS' duty to conduct the State's business in such a way as to protect the public. In order to so protect, DSHS will not disclose bids before contract(s) are signed. Thereafter, the responses shall be deemed public records..." Does this mean that none of the responses (i.e., bids) will be released until all contracts for all RSNs have been signed? If a specific RSN is an unsuccessful responder, and therefore will have no contract, will that RSNs response still become public record and if so, at what point? If it does become public record and a bidder to the RFP requests that RSN's response, how will DSHS handle this request (since it could possibly constitute an advantage to the RFP bidder)?	The disclosure of proposals, successful or unsuccessful, will not occur until all contracts resulting from the RFQ are executed. These documents are public records under state law and may be released upon proper request at the proper time. The proper time is after execution of all the contracts. Any request for a public record will be complied with in accordance with state law. Since the same information will be available to any party, a request for a public record does not constitute an advantage to a potential bidder to a possible RFP.	
45.	Section 2.19 Evaluation, Scoring and Criteria Subsection, 2.19.3 Mandatory Scored Requirements. The second paragraph states that "A score of 0 is grounds for disqualification…" In a previous section, 2.11 Response Preparation Requirements, the first paragraph states that "Failure to provide an adequate answer to any [MR or MSR] subsection that requests information or solicits an answer may cause the response to be deemed non-responsive and be disqualified from the evaluation process". These two statements suggest that if an RSN receives any 0 scores,	The RSN must answer all of the questions in the RFQ in order to qualify. A score of 0 will be figured into the 70%. A score of 0 may also result in a disqualification. To be considered substantially compliant and be eligible for award of contracts as a result of this RFQ, an RSN must receive 70% of the total available points for all MSRs. Each section marked as MSR is worth a maximum of 5 points and will be scored as a whole.	

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	even on MSRs and even though it may receive more than 70% of total available MSR points for other responses, it will be disqualified. Is this correct? The paragraph following 2.19.3.5 states that "…an RSN must receive 70% of the total available points for all MSRs." How will the 70% be calculated? Will it be based on the overall MSR Section (e.g., 3.1.4 Consumer Participation)? OR Will it be based on the points for each question under the MSR (e.g. Consumer Participation questions 3.1.4.1 through 3.1.4.6)?	The RFQ states: 'Evaluators will score MSR on a scale of 0 to 5 points. A score of 0 is grounds for disqualification…'	
46.	Section 2.21 Debriefing and Protest Procedure Subsection 2.21.2.2.3 lists "bias, discrimination, or conflict of interest on the part of an evaluator" as one of the possible grounds for protest of the DSHS decision about an RFQ response. How will DSHS assure an absence of bias, discrimination or conflict of interest on the part of the evaluators? Given that RSN responses will be rated by evaluation teams (subsection 2.19.5), how will DSHS ensure inter-rater reliability?	DSHS has a process whereby evaluators are selected and certified. Evaluators must sign declaratory statements affirming their lack of potential conflict of interest and providing an assurance of confidentiality. Evaluators cannot have a substantial financial interest in the outcome of the selection and can not be an employee, consultant, officer, director or trustee of any organization submitting a response. Evaluators certify that they will perform their function in an unbiased and objective manner. Inter-rater reliability is not an issue as the evaluation teams for this project will review proposals from every RSN submitting a response and scoring will be by consensus.	
47.	Section 3.1 Special Initiatives Subsection 3.1.3.2 addresses consumer-operated services. Does "consumer-operated services" mean clinical services only or can it also include consumer-operated businesses?	Yes this can include consumer operated businesses.	
48.	Section 3.1.8 Evidence-Based, Research-Based, Consensus-Based, and Promising or Emerging Best Practices Questions.	RSN's are expected to provide actual copies of formally adopted policies and procedures. Contracts and other documentation	

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	In Subsection 3.1.8.3, and in other sections and subsections, there is the requirement that RSNs provide "written policies and procedures, which have been formally adopted by the RSN…" What will constitute evidence of written policies and procedures? Can it include contract language or other documentation, as well as formal policies and procedures?	can support the policies and procedures, but cannot replace them.	
49.	Section 3.3 Information System Requirements Subsection 3.3.2.3 requests RSNs to "Provide written policies and procedures…regarding the submission of encounters." Does this include both encounters from subcontractors to RSN and encounters from RSN to MHD? In Subsection 3.3.2.6, and in other sections and subsections, there is the statement "Describe how the RSN measures and reports outcomes for the requirements." Please clarify what is meant by this term. For example, in Subsection 3.4.6 Disaster Response, a requirement is for the RSN to "attend MHD-sponsored training regarding the role of the public mental health system in disaster preparedness and response." How would an RSN develop "measures and outcomes" for this kind of a requirement?	Yes, include policies and procedures for both types of encounters. The RSN must describe the performance measures and reporting mechanisms for the particular section. For the training example referenced this could include, training attendance records and subsequent implementation of the subject matter of the training, including tracking, reporting and monitoring of disaster preparedness activities.	
50.	Subsection 3.3.4.2 requests RSNs to "Provide written policies and procedures…addressing the loading all enrollment, demographic data, and eligibility updates into an information system." Please clarify the terms "enrollment" and "eligibility".	For the purpose of answering this question, enrollment and eligibility have the same meaning.	

Q#	Question	Answer	RFQ Amendment
51.	3.4 Section RSN Program Requirements From a review of the definition for Subsection 3.4.1.5.22 Mental Health Clubhouse, it appears that new requirements for Clubhouse have been written into the description. These include: "Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines" and 3.4.1.5.22.4 "Operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday." Neither of these requirements appeared in the state Mental Health Division's state plan modality descriptions, published in January 2005. The Mental Health Division has consistently stated that new language cannot be added to the modalities because the existing language is part of the waiver that has been accepted by the Center for Medicare and Medicaid Services. What is the justification for adding this language in the RFQ description?	The standards for Clubhouse were established in the RFQ based on consumer input and national standards. Determining hours of operation and the establishment of operating guidelines are not precluded by the definition of Mental Health Clubhouse in the Waiver.	
52.	Subsections 3.4.2.6 and 3.4.4.4 announce a new requirement that RSNs "Provide a written plan with a schedule describing how the RSN will have a system in place to pay community hospitals directly without using DSHS as an intermediary by September 1, 2006." Why is the State asking RSNs to take on this new responsibility? What are the expected benefits? How will the Mental Health Division allocate inpatient funds to the RSNs so that the RSNs have the resources to pay the community hospitals? Will the current provider agreement with DSHS that governs the hospital rates be maintained, or will RSNs be required to separately contract with each hospital in the state and negotiate rates? If RSNs are responsible for payment of professional services,	See answer to question 14.	

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	medications, laboratory tests, care provided for physical health care problems, transportation costs and other items, will all the funding be transferred to RSNs regardless of where the funds are currently budgeted? Does this responsibility apply to any claim that is submitted after August 31, 2005 (for admissions authorized prior to that date), or to claims that are submitted for inpatient authorizations that happen on September 1, 2006 or later? Will this require the RSNs to have any responsibility for the Medicare/Medicaid population? If so, will those responsibilities be for payment only or will we be involved in authorizations, claims processing, quality improvement, etc.? Part of claims processing is confirming eligibility and ensuring that all other insurers are billed first. How will we access the needed information in these areas? Will all requirements in #01-03 MAA be dropped? If not, which will remain? Given that this is a totally new requirement for RSNs, and that no notice of this new requirement was given prior to the issuance of the RFQ, what level of detail is the State looking for in the plan?		
53.	Section 3.4.7 General Information Requirements Subsection 3.4.7.1.1 lists Access to Care as a topic for which information must be provided to persons served by the RSN. Does this refer to access to services in general or the state Mental Health Division's Access to Care Standards?	The requirement refers to the MHD Access to Care Standards.	
54.	Section 3.4.13 Eligibility Verification and Determination Requirements Subsection 3.4.13.1 states that "DSHS shall determine eligibility for	(a) No. DSHS will continue to provide real time data for individual clients through the current mechanisms. (b) If the RSN delegates these functions the RSN must submit a	

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	Title XIX services and provide eligibility data to the RSNs." (a) Does this mean that DSHS will be providing real time eligibility information that is accessible for more than one client at a time? Subsection 3.4.13.3 states that "The RSN must have a subcontract or agreement that outlines deliverables for any delegated functions." (b) How does subcontracting for delegated functions relate to Eligibility Verification and Determination?	delegation plan.	
55.	Section 3.4.16 Provider Network Questions Subsection 3.4.16.3 The instructions for completion of the table "Types of Residential Facilities" state "*Do not include Mental Health Services Provided in a Residential Setting in this Table,"* yet the information requested about Supported Housing is related to mental health services provided in a residential setting. Please clarify what information is being requested.	The question requires a bed count of all residential programs. The question does not require a count of the services provided to support those beds.	
56.	Section 3.4.30 Quality Assurance/Performance Improvement Program Questions Subsection 3.4.30.8 requests RSNs to "Provide one example of how the RSN implemented a quality improvement initiative for …consumers receiving State-funded services resulting from QA/PI activities in FY 2005." Implementing a quality improvement initiative for consumers receiving state funded services does not relate to any contract requirements that RSNs had for state funded services in FY 2005. How should RSNs interpret this part of the overall question?	The RFQ is amended to read: Provide two examples of how the RSN implemented quality improvement initiatives resulting from QA/PI activities prior to September 1, 2005.	Yes
57.	Is there a planned site visit by DSHS for those RSN's who are deemed an "Apparently Successful RSN (ASR)"?	DSHS reserves the right to make site visits.	
58.	In Section 3.4.21.5, a 10 day limit is specified. Are these business days or calendar days?	The RFQ has been amended to read: business days.	Yes
59.	In Section 2.9.3, DSHS reserves the right, at any time before execution	Any revision to the RFQ prior to the due date will require a	

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	of contracts, to revise all or a portion of this RFQ and/or to issue amendment(s) to the RFQ. That means that even after responses are delivered on or before December 1, 2005, DSHS can change the terms of the RFQ. Will revisions that are made too late to be incorporated into the RFQ response be considered "binding", as defined in Section 2.5?	response from the RSN in their proposal. Revisions to the RFQ after the due date are unlikely. If there is a revision after the due date that revision will address additional time for RSN's to respond.	
60.	In Section 3.2.1., the RFQ states that "Signing the submittal letter indicates that the RSN accepts the terms and conditions of this RFQ and that the RSN acknowledges and agrees to all of the rights of DSHS including the RFQ rules and procedures, terms and conditions and all other rights and terms specified in this RFQ, including any amendments." Is this statement intended to include all terms contained in the model contracts?	Yes, the signed letter of submittal includes acceptance of the model contracts.	
61.	Regarding indemnification language in the Model Contract (Section 17.11): In both the current MHD agreements and in the DSHS General Terms and Conditions, Indemnification and Hold Harmless are defined as mutual. In the model contract, the language is unilateral. Can the indemnification be redefined as mutual, in accord with current contracts? If not, what is the rationale for limiting it to unilateral indemnification?	DSHS has no legal authority to enter into indemnification agreements and cannot indemnify the RSN under this contract. See answer to question 64.	
62.	Section 3.2.10.3. asks the responder to "Describe how the RSN measures and reports outcomes for the requirements." Does this apply only to required financial reports under specified in Section 3.2.9.1, or are other measures and reports to be included in the response? If others are required, please describe the additional types of measures or reports to be included?	Section 3.2.10.3 applies to both financial and all other data submitted to MHD. The RSN must describe how the RSN measures and reports outcomes, such as measures of accuracy and timeliness. See also the answer to question 83.	
63.	Section 3.4.16.6 and 7. Please identify whether this is fiscal or calendar year?	The RFQ is amended to read: Calendar year	Yes
64.	In Sections 2.4 and 2.5, the submission of a response by the County/RSN is described as a "binding offer" and "the terms of the contract (models in Exhibits B and C) are not subject to negotiation. Since the Secretary of DSHS, Robin Arnold Williams, and Kathleen Brockman of central contracting have committed to negotiating the general terms and conditions, and the special terms and conditions of DSHS contracts, how will DSHS reconcile this apparent inconsistency?	Negotiations began 11/02/05, with the counties over the DSHS and County Agreement on General Terms and conditions. Although this Agreement and the RSN Contracts are legally separate and distinct, it is anticipated that the general terms and conditions in each will mirror the other. Contracts will be changed to reflect any modifications made as result of these negotiations.	

Q#	Question	Answer	RFQ Amendment
65.	3.4.29.3.1 requires the RSN to meet or exceed a Medicaid Penetration Rate of 10%. Please clarify which service provided to a recipient makes them eligible for measurement in the penetration rate. Inpatient, outpatient, crisis, crisis calls Clubhouse, other services, etc?	Any Medicaid service provided to a Medicaid enrollee.	
66.	For clarity, we note that throughout Section 3 of the RFQ and the sample PIHP contract there is repeated and apparent interchangeable reference to: "days" [e.g., section 3.2.17 {page 37} of Section 3 of the RFQ] "calendar days" [e.g., section 4.10 of the PIHP] "working days" [e.g., Section 3.4.1.5.9 {page 47} of Section 3 of the RFQ] "business days" [e.g., Section 16.14 of the PIHP] This creates confusion and uncertainty. Is there a difference between a "working" day and a "business" day? If the sentence does not use the words "calendar days", does that automatically mean that the reference to "days" is to "business or working" days? Put another way, if the sentence in question only states "days," is it referring to "business/working" days or "calendar" days?	For clarity: When the RFQ or contracts state "days" or "calendar days" the meaning is the same. When the RFQ or contracts state "working days" or "business days" the meaning is the same.	
67.	We would respectfully request that the reference to contract in the RFQ be changed to "unilateral contract" to more accurately reflect that the terms are non-negotiable. A contract is universally defined and understood as an "agreement between parties", and the statement that terms of the contract will not be negotiated makes the use of this term inappropriate.	The request is acknowledged, no changes made.	
68.	Please clarify what resources will be transferred by DSHS to the RSNs in order to pay community hospitals directly without using DSHS as an intermediary by September 2006.	See answer to question 14.	
69.	3.4.1.5.5 references a facility that is "inpatient residential (non-hospital/non-IMD). From which the individual is "….. discharged as soon as a less-restrictive plan can be safely implemented." Please clarify what is meant by an inpatient residential facility. It would seem these terms are mutually exclusive.	The phrase "inpatient residential" comes directly from the currently approved definition in the Medicaid State Plan Amendment for Freestanding Evaluation and Treatment.	
70.	RCW 71.24.30 states: "The department shall require each regional support network to provide for a separately funded mental health	The contracts are amended to read:	

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	ombudsman office in each regional support network that is independent of the regional support network. The ombudsman office shall maximize the use of consumer advocates." Since the statute does not include the language used in the draft contract, please clarify the use of the term "affiliation" in regards to the Ombuds requirement of Section 9.5.	The Contractor shall provide a mental health ombuds as described in WAC 388-865-0250 and RCW 71.24 as amended by Laws of 2005, ch. 504 (E2SSB 5763). The mental health ombuds cannot be employed or otherwise controlled by the Contractor.	
71.	1.30. Operating Reserve means funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN/PIHP governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services. 4.12. The Contractor may have an additional Operating Reserve, not to exceed 5% of the Contractor's estimated annual Medicaid Capitation payment. And 5.3.7. The Contractor shall report the level of PIHP Operating Reserve and Risk Reserve accounts and unobligated mental health fund balances to MHD according to the BARS Supplemental Instructions issued by the State Auditor. Please clarify these sections. The last section standing alone seems to indicate that an RSN could have ONLY a 5% operating reserve but if put with the 1.30 section, perhaps the intent is that the RSN can have 5% additional to required cash flow provisions. Given the fiduciary responsibilities added to the PIHP, this would be an important clarification.	• The term "additional," in reference to the Operating Reserve, means in addition to the Risk Reserve. • 4.12 means that in addition to the Risk Reserve, the RSN may have an Operating Reserve not to exceed 5% of the annual Medicaid Capitation payment. • 1.30 clarifies the purpose of Operating Reserve.	
72.	10% Admin. Cost limits: When calculating the limit on Administration (10%), it states "10% of the total RSN revenue". Does this mean 10% of all RSN revenue?	The 10% will be calculated based on RSN total revenue reported on the Revenue and Expenditure report. In the BARS manual, it states that the RSNs should report all revenue received to the Mental Health Division. It further states that revenues received directly by providers should not be reported to the Mental Health Division unless it is to be used as local match to draw down the federal funds.	

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	GCBH (PIHP + SO + FBG + Interest Income) Providers (3rd party Collections + Other MH Income) Member Governments(counties) (Property Tax + Interest+ Other Income) Total RSN income x 10%= Limit Or is it only calculated on RSN Income (Ignoring the remaining two)?	If the RSNs receives other revenue and the revenues are used to provide mental health services, then the revenues must be reported in the R&E.	
73.	Separate Budget: GCBH currently uses 1 fund and 1 fund number. Should GCBH create an entirely new Fund to administer state resources? Or, can that 1 fund, have it's budget amended into separate departments within that same fund?	MHD requires that each RSN have at least one fund to account for mental health activities separate from other business (services) the RSN provides (DASA, etc.). Two funds are recommended to account for Medicaid and state only separately. If two funds are not established, the RSN is required to demonstrate that the accounting system (by account coding) tracks expenditures by fund source.	
74.	3.2.17 Timeliness of Provider Payment Requirements (a) Is it the intention that under the new contract the RSNs will be required to pay for all Medicaid services from a fee schedule? (b) We understand rates are pending CMS approval, when do you estimate the Medicaid fee schedules will be available to the RSNs? This question arises out of the language of RFQ sections 3.2.17 from the "2006-2007 PIHP draft contract for RFQ" section 4.9 and from the claims payment procedures described in 1902(a)(37)(A) of the Social Security Act and 42CFR447.45.	(a) No, it is not the intention that under the new contract the RSNs will be required to pay for all Medicaid services from a fee schedule. The requirement is to pay claims in a timely manner if the RSN or RSN delegate pays FFS. (b) There are no questions in RFQ that require a Medicaid Fee schedule in order to respond. .	
75.	2006-2007 PIHP Draft contract for RFQ Sections 4.11 and 4.12 (a) Are the Risk and Operating Reserves independent of any title XIX reserves accumulated prior to this contract? (b) Are Title XIX reserves accumulated prior to this contract subject to recapture by the MHD?	(a) Reserve accounts are balance sheet accounts. By definition, they are continuous (accumulated). Per Contract, the RSNs are required to maintain risk reserve at the required percentage and allowed to have Operating Reserve up to 5% of annual Medicaid revenue regardless of when the funding is accumulated. (b) The recapture of reserves is not a subject of the RFQ.	
76.	2006-2007 State Only draft contract for RFQ Section 4.4 (a) Is the Operating Reserve independent of any State Only reserves	(a) No, the Operating Reserve is allowed up to 5% of annual state only revenue regardless of when the funding is accumulated.	

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	accumulated prior to this contract? (b) Are State only reserves accumulated prior to this contract subject to recapture by the MHD?	(b) The recapture of reserves is not a subject of the RFQ.	
77.	3.3.2.2 – For attachments to be sent that contain client information, we can black out the hard copy originals, but the electronic versions will be saved as pdf files. Can we send sub-runs, that eliminate the client id – or should we manipulate the pdf the best we can to eliminate the client id?	For the purposes of the electronic version of attachments containing client information that needs to be redacted for confidentiality purposes, either a sub-run or pdf manipulation would be acceptable.	
78.	2.1.2 Response Submission Format: Are Adobe pdf files acceptable for attachments? Some of these are data report files that are only available in pdf and other attachments are scanned files saved as pdf.	Yes	
79.	3.2.6 Are annual State audit reports acceptable to verify financial status, solvency, and viability of the RSN?	See answer to question 22.	
80.	In the amendment issued on 10-10-05 a change in the numbering sequence occurred. 3.4.24.5 in the original RFQ is shown as 3.4.24.4.1, and so on, in the amendment. Is the numbering in the amendment dated 10-10-05 the correct numbering?	We will check the numbering format in the amended RFQ and contracts. Use the numbers in the amended RFQ.	
81.	Please clarify the evidence-based/promising practice on Medication Algorithms-Medicaid/MOSES. What are you wanting? This is especially confusing for SAMHSA has recently removed the Medication Management evidence-based practice from their web-site for there were problems with it. We know that the MOSES is a process to check for medication side-effects. In this evidence-based practice, what does Medicaid/MOSES reference?	In the table under 3.1.7.2. "Medication Algorithms-Medicaid/MOSES" is changed to "Medication Algorithms".	Yes
82.	Section 3.1.7.1. states that the RSN shall integrate eight core evidence-based practices and four priority evidence-based and promising practices have been selected by DSHS for implementation. (a) We count nine core EBPs. Was eight a typographical error? (b) Please provide a crosswalk of these EBPs to the services listed in 3.4.1 to clarify relationship to the approved Medicaid State Plan (and prevent a situation where the contract requires the RSN to provide services that are not Medicaid approved).	(a) Yes, it is an error. The RFQ is amended to change the number of practices to nine. (b) A crosswalk is not available. (c) An EBP may meet the requirements of a practice guideline, but practice guidelines are a broader group of clinical standards.	Yes

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	(c) What is the relationship between the implementation of EBPs and the implementation of practice guidelines as outlined in 3.4.19?		
83.	Section 3.2.10.3 requires bidders to describe how the RSN measures and reports outcomes for the requirements. This question appears in multiple places in the RFQ. Please confirm/clarify if this means that the RSN must describe the performance metrics for the particular segment under discussion (in this case, the assurance that reports are complete, accurate, and timely) and how those metrics will be tracked and reported within the RSN as well as to the MHD.	The understanding of the requirement described in the question is correct.	
84.	In Section 3.2.18 there is a mandatory requirement to ensure that claims that result in actual cash payments are accurate and provided on a timely basis. What is the definition of "claims that result in actual cash payments to providers"? Does this include case rate payments? Sub-capitation payments that are adjusted up or down based on the volume of claims? Payments that are a mix of fee for service and fixed payments?	See the answer to question 74. The timeliness requirement does not apply to capitation or case rate payments.	
85.	The PIHP model contract section 4.6.3 references the current utilization deduction method for community inpatient obligations as part of the reconciliation language—this seems to be in conflict with the RFQ requirements in sections 3.4.2.6 and 3.4.4.4 to pay hospitals directly. Will the wording of the contract change or does 4.6.3 describe a transitional mechanism only?	See the answer to question number 14.	
86.	The PIHP contract section 4.11 has a blank for percentage of risk reserve. Is MHD contemplating a change in the required percentage?	No, the blank is appropriate. The contract is a model and the reserve amount varies by RSN. For any RFQ response that would require a reserve amount, the RSN should base the amount on the current contract.	
87.	Section 11.4.1.2 describes the encounter validation checking process. Is the required encounter validation check of 1% or 250 records for the	The encounter validation check is for the entire subcontracted provider system.	

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	entire subcontracted provider system or for each provider?		
88.	Section 3.4.1.5. states that "Mental Health Rehabilitation Services are integrated treatment services recommended by a mental health professional and furnished by State licensed Community Mental Health Agencies, except for MH Clubhouse." Must FQHCs become licensed Community Mental Health Agencies in order to receive Medicaid reimbursement for mental health rehabilitation services?	Services under contracts resulting from the RFQ, except for mental health clubhouse, must be provided by or be contracted by a CMHA.	
89.	Section 3.4.15.6 describes the geographic accessibility standards to care. Please confirm/clarify if the travel time access requirements apply to each of the specific outpatient services listed in 3.4.1 and 3.4.3 as well as EBPs?	Distance standards are to a CMHA not to a specific service.	
90.	In Section 3.4.23 there is a requirement that authorization and utilization management shall be provided by the RSN or a delegate that is not a CMHA and that the RSN must have processes to determine medical necessity (3.4.23.2), review treatment plans (3.4.23.3), and authorizing care (3.4.23.4). If a consumer appears at, or calls into, a community mental health agency, may the agency initiate the request for an intake evaluation on behalf of the consumer?	The RSN must have an authorization process for intake evaluations. Yes. The provider can initiate an authorization with the RSN on behalf of the consumer.	
91.	The model PIHP contract Section 10.2.1 describes the Resource Management plan. Is the Resource Management Plan identified as required in the PIHP contract (10.2.1) the same as the UM Plan required in the RFQ?	The elements may overlap. The RSN response must the address the questions in the RFQ.	
92.	I submitted some questions more than a week ago. When may I expect to see the answers on the webpage?	No response.	
93.	2.12 Response Submission Format Must the "one electronic copy" of the RSN/PIHP response include all the attached, supporting documentation (e.g. policies, plans)? In the "hard copy" this documentation will be easy to attach.	See answers to questions 5 and 43. The electronic copy must be complete. All copies must be in a binder.	

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	However, converting some of this documentation material into the "one electronic copy" appears to be problematic, and in some cases improbable. Can the "one electronic copy" contain only the RFQ response? Does only the one "Original" response go in a three-ring binder? Or do the seven copies go in three-ring binders as well? Do attached "materials and enclosures" have to be in 12 point font? Some existing documents/attachments may use 12 point font.		
94.	3.1.7. Evidence-Based Practices 3.1.7.1. States "The following eight core practices have been selected by DSHS for implementation." However, the following Table contains nine core practices. What is the meaning of this discrepancy?	See answer to question 82.	Yes
95.	3.2.1. Letter of Submittal 3.2.1.4. Requires a "detailed list of all materials and enclosures included in your response." What does "detailed" entail? Will the names of the materials and enclosures suffice?	Yes, the list of materials enclosed will be sufficient.	
96.	3.3.1. Encounter Date Requirements 3.3.1.2. States "HIPAA format 837I is used to submit encounters for most hospital services including outpatient, inpatient and residential settings." This is in contradiction to the current practice of sending hospital-based day outpatient treatment/partial hospitalization as an outpatient service in the 837P format. How should this contradiction be resolved? The RSN/PIHP also submits any services delivered in the hospital by	Prepare your response assuming you will continue what you are doing now. • Use 837I to send inpatient hospital stays (room and board; admit and discharge types of information). • Use 837P to send in outpatient services, including those provided by professional staff coming into a hospital to see consumers.	

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	outpatient providers as outpatient services in the 837P format. An example would be intake services performed prior to a client being released from the hospital. Additionally, for reporting under the state only budget we would be reporting intakes done by agencies prior to discharge in the 837P format. Again, How should this contradiction be resolved?		
97.	3.3.1. Encounter Data Requirements 3.3.2.2. States "Provide copies of submission reports that are generated during the encounter submission process, both from subcontractors to the RSN and from the RSN to MHD." If a subcontractor submits data to the RSN via manual direct data entry is a submission report required? If so what elements should be documented?	No, a submission report is not required if the data is submitted via manual direct entry.	
98.	3.3.3. Enrollment and Demographic Data Requirements 3.3.3.2. States "The RSN must be able to receive electronic eligibility information that will be used to establish or terminate client eligibility. RSN must also be able to process retroactive changes in a client's status. Claims affected by eligibility retroactivity must be reprocessed based on the new client status." (a) Can the RSN expect to receive timely HIPAA compliant eligibility transactions from MHD that contain sufficient information to establish eligibility for mental health services under TXIX or any state funded programs that provide access to mental health service provided by the RSN? (b) Will MHD's calculation of timely data submission (within 60 days of end of month of service date) be amended to count as timely RSN submission of claims that must be processed after this 60 day window due to new client status?	(a) The RSN's should respond to the question assuming the eligibility data will be the same as it is currently. (b) The requirement is to submit all encounters within the 60 day timeframe. RSN's will not be penalized for encounters submitted outside of the 60 day window because of retroactive eligibility determinations.	
99.	3.4.1. Title XIX Service Requirements	(a) There is no limit on the number of times an intake can be reported.	

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	3.4.1.3. States “All Medicaid enrollees requesting covered mental health services must be offered an intake evaluation as defined in the Medicaid State Plan. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services." (a) How often can an intake be reported? (b) If a client drops out of service and re-enters service within a short period of time does another intake need to be done? If a client transfers between agencies does another intake need to be done? If a client receives services from multiple agencies in the system of care does each need to perform and report an intake?	(b) The RSN must have policies and procedures that address all of the issues identified in this question.	
100.	The RFQ states "Effective September 1, 2006 the RSN must have a system in place to pay community hospitals directly without using DSHS as an intermediary." This requirement is reiterated in 3.4.2.6. and 3.4.4.4. Currently, if a client is detained, the detaining RSN gives the hospital a certification number which allows the facility to bill, even if there is a question about whether that client resides in another RSN. During claims adjudication MAA reassigns the claim if the client CSO is from another RSN. How would this happen with each RSN doing its own claims payment? Additionally, how will additional claims, not reassigned but disputed, be adjudicated and funds reconciled?	See answer to question 14.	
101.	Why does the state contract contain Medicaid enrollee information and why does it discuss Medicaid Personal Care hours? It appears as though the Medicaid contract was “cut and pasted” into the State-Only contract.	Medicaid Personal Care is funded by the RSN’s with State Only funds. Aging and Disability Services Administration pays the Federal portion. This is consistent with the contract currently in place. This service is available to Medicaid enrollees only. The RSN does not directly provide the service.	
102.	3.4.1.5.1 - 3.4.1.5.22 Defines state plan services.	(a) No, for purposes of responding to this section of the RFQ,	

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	(a) Do we need to also incorporate restriction on service delivery/reporting as set forth in the MHD Public Mental Health Service Reporting Manual? (b) Is that document the definitive source for interpretation of state plan service reporting? This is especially pertinent around definitions of ancillary services that can be reported coincident with another state plan service.	RSNs do not need to incorporate the restrictions on service delivery/reporting in the MHD Public Mental Health Service Reporting Manual. (b) This document is a guideline for reporting.	
103.	3.4.13.1. States "DSHS shall determine eligibility for Title XIX services and provide eligibility data to the RSN." How will this be provided? Will this be in a format that will allow contracted agencies real time and batch access to eligibility queries for Title XIX?	See answer to question 54.	
104.	3.4.13.2. Describes the process for determining eligibility for State-funded mental health services. What requirements are there for State Funded consumers? 3.4.14.2. States "Describe the process for determining eligibility for State-funded mental health services." What does the RFQ mean by eligibility for state funded mental health services? If a service is not TXIX funded then isn't the eligibility just medical eligibility, i.e. ITA services, non-state plan services etc.?	The RSN is required to provide ITA, Crisis, and Medicaid Personal Care. The contract describes the criteria for each of these services. The RSN determines criteria for State funded consumers to receive outpatient and residential services within the parameters of resources available. The criteria for authorization of services cannot be less restrictive than the Access to Care Standards. The RFQ question requires that the RSN describe its own process for determine eligibility for State funded services.	
105.	<u>In the RFQ Section 3.4.13, Eligibility Verification and Determination Requirements</u> There is no stated restriction, as there is for Customer Services (3.4.11), that would not allow this function to be delegated by the RSN to a provider of services.	Customer service may not be delegated to any network provider. It may be delegated to an ASO.	

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	Is delegation allowed either to an ASO or provider?		
106.	In the RFQ Section 3.4.21/22 Access Requirements It indicates that the RSN care managers provide telephone assessment and referral services and arrange for an intake evaluation for routine services or State-funded services, as appropriate. Please clarify whether or not all requests for services must first be authorized by the RSN prior to intake? For instance, is it possible for a consumer to self-refer to an RSN-contracted outpatient provider to schedule an intake assessment, or must they all be referred first to the RSN Care Manager, who then does a telephone screening and may refer the consumer back to the provider of choice?	The RSN must have a process for authorizing all services including intake. For Medicaid enrollees requesting an intake this would include only two things: 1. Are they Medicaid enrolled? 2. Is there a current intake that establishes medical necessity? All other services would be authorized based on Medical Necessity. For State only consumers, the RSN must have a process for authorizing all services including intake. Authorization decisions will be in accordance with the RSN's policies and procedures for State funded services. The provider could initiate the authorization with the RSN when the consumer presents to the provider. The contracts have been amended to reflect the RSN's responsibility to authorize an intake. See sections 12.10 and 12.11.2 of the State Only contract and sections 6.2.2 and 6.2.2.1 in the PIHP contract. Numbering in these sections has changed with this amendment.	Yes
107.	In the RFQ Sections 3.4.17/18, Care Management Requirements and Sections 3.4.23/24, Authorization and Utilization Management Requirements Please verify that the RSN's Care Management function responsibilities could be covered by Deciding that the initial intake evaluation for outpatient services does not require pre-authorization, assuming that the CMHA provider, to whom the consumer was referred, has been delegated by subcontract to verify eligibility for Title XIX and state-funded requirements? Deciding that an initial authorization for subsequent care after the	The requirements stated in the RFQ are more extensive than those listed in this question. It appears that the Care Management functions described do not meet the requirement.	

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	intake assessment can be completed by the RSN Care Manager(s) after reviewing a required eligibility and medical necessity data set from the provider who conducted the intake assessment, and submitted a request for specific level of care, under the RSN Clinical Care Guidelines, based on the intake assessment information? Deciding that concurrent review for continued stay, based on the authorized level of care, can be completed by the RSN Care Managers based on an established algorithm or automated random selection process? RSN-designated psychiatric medical director consultant reviews all denials of care and actions on care authorization?		
108.	In the RFQ Section 3.4.23, Authorization and Utilization Management Requirements The RSN is required in subsection 3.4.23.3 to have a process for review of treatment plan, in order to ensure certain requirements are met. In the sample PIHP contract, Section 10.2.4, the terms indicate that the RSN's care management system must include a review of the Individual Service Plan, to ensure the WAC requirements are met. Does this mean the RSN must require that the subcontracted provider conduct such treatment plan reviews, for instance, as part of their QI Peer Review process, to confirm all the specified requirements are met, and this process is reviewed periodically by the RSN Care Managers? OR Does this require the RSN Care Managers to actually review all individual treatment plans of individual consumers at each subcontracted provider?	The RSN determines its own process to meet the treatment plan review requirements. 3.4.24 contains the questions the RSN must respond to in order to address the requirements in 3.4.23.	
109.	In the RFQ Sample State Only contract, under Section 12, Services, there is some confusion on the labeling of subsections, beginning on page 30:	Formatting will be corrected in the final contracts prior to execution. The detail is intended to follow the header.	

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	For Subsection 12.6, there is a bolded title, Inpatient Coordination of Care, but no detail. For Subsection 12.7, there is no title, but a series of details. Is this a typo, and the detail in Subsection 12.7, is actually intended to come under the Subsection 12.6 title?		
110.	The RFQ Section 3.2.6 speaks to Financial Stability and Viability. Is the RSN totally at financial risk for services rendered, or may that risk be shared or delegated to providers?	RSNs carry full financial risk. The structure of contracts with RSN sub-contractors is not determined by DSHS.	
111.	Are the current answers to the questions that were handed out still draft?	As was stated at the pre-proposal conference, the questions and answers provided at pre-proposal conference were not final.	
112.	Our questions from October 4th are pending. When can we expect final answers?	One week following the deadline for questions.	
113.	It seems odd that the question about eligibility is still pending.	See the answer to questions 50 and 54.	
114.	(a) There are multiple elements to the letter of submittal; do you want this in a letter format? (b) This would be a long letter.	(a) Yes, letter format. (b) Acknowledged	
115.	The contract excludes inpatient service in the travel standards, at another place in the contract it talks about an E&T being needed. (a) Will this be excluded from the travel standards? (b) Are inpatient settings to be included in GeoAccess? What would the travel standards be?	(a) The travel standard does not include E&Ts. (b) There are no travel standards for inpatient care. The Access analysis should include all service providers.	
116.	Question 10 of the handout asks that 0-5 be defined. Can we get info on what a 2,3,4, are? That would be helpful.	0 is defined at 2.19.3 and 5 is the maximum possible score for any section. 1, 2, 3 and 4 are gradations between 0 and 5 that are not defined in the RFQ.	
117.	Can we get a break out of 2,3,4,5.?	See answer to question 116.	
118.	If there are multiple questions for a section scored MSR and one or more questions is not answered - is that a zero? Will this disqualify the RSN?	Yes, if an RSN does not respond to a question or is non-responsive, the RSN may be considered non-responsive for the mandatory scored section. A score of zero is grounds for	

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		disqualification.	
119.	What if one of the questions is considered non-responsive. Would this result is zero?	See answer to question 118.	
120.	In the allied systems requirements and questions RSNs must draft 30 working agreements or include a plan for allied systems with which the RSN does not have a working agreement. (a) If the RSN fails to address any allied system, could the RSN receive a score of 0? (b) Are there only five points for this section?	See answer to question 122. (a) If the evaluators consider the RSN response non-responsive the RSN could receive a score of 0. (b) Yes, there is a maximum of 5 points possible for the Requirement.	
121.	Do you attach P&Ps to questions?	See the answer to question 5	
122.	What do we do about MOUs with allied services? What if entity refuses to execute an MOU with the RSN?	The RFQ requires a coordination plan. If there is no coordination plan in place the RSN may submit a description of the RSN's current processes for coordination along with a project plan. The RFQ does not require MOUs or working agreements. The development of MOU and/or working agreements could be part of the coordination plan.	
123.	Criminal Justice, is the expectation that we would have working agreements with all the named entities?	See answer to question 122.	
124.	What is the expectation that you have a MOU all the school districts?	See answer to question 122.	
125.	Do you want us to have a plan for EBPs that have not been officially recognized by the MHD? How can we implement them?	The RFQ requires a description of plans the RSN has to increase access to EBP's. It does not require a plan for any specific EBP. RSN's can implement any EBP or promising practice, DSHS has prioritized the lists included in the RFQ.	
126.	Will DSHS be publishing explanatory notes prepared by DSHS for evaluators?	No.	
127.	Question 52 in the handout – DSHS contracts will not govern RSN payments to the hospital. Would this be money in addition to the MAA payment?	See answer to question 14.	
128.	Payment for GAU clients is too low to come from RSNs. You are putting the system at risk of blow up with this change.	See answer to question 14.	
129.	In the event the RSN's assume contracting responsibility for community inpatient care. We have an IMD while they are in the IMD	See answer to question 14.	

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	and are then sent out for medical care this changes the responsibility for medical care. How will this be addressed?		
130.	How will the travel standards be measured, by county or by RSN?	By RSN service area.	
131.	Why did DSHS choose the Requirement/Question format for responses?	For ease of evaluation.	
132.	Confused about MR question or MSR sub section there are sometimes many questions. If some of those questions are not answered within a requirement does that mean the RSN is disqualified?	See answer to question 118.	
133.	Question 52 in the handout - Could you please let us know what we will be responsible for the things in the list. Not just physical health care?	See answer to question 14.	
134.	We have been overseeing authorization, over that period time our RSN has approved care for children with eating disorders. These bills have never showed up. We are told we are responsible even though MHD has never caught these bills. We need to know exactly what we are paying for if we are going to pay the bills--including ancillary care and many other unknowns. We need the department to clarify which discharge diagnosis and ancillary care we will be paying for?	See answer to question 14.	
135.	Ten-day limit specified as calendar in the response, this is in conflict with the contracts attached.	See answer to question 58.	Yes
136.	State Contract, PIHP and the RFQ – Mental Health Clubhouse, definitions are all a little bit different. Please clarify.	Both of the model contracts are amended to match the definition in the RFQ.	Yes
137.	Question 90 in the handout – What clinical information would be needed for an authorization for intake?	See answer to question 106.	
138.	In the state contract there are references to Medicaid eligible. Is this a mistake?	No, this is not a mistake. The State Funded Contract refers to Medicaid Personal Care (MPC). RSN's are responsible for providing the state only funds used to obtain Federal Financial Participation for MPC. The State funded contract also allows for non-Medicaid services to be provided to Medicaid enrollees.	
139.	Is the contract binding as written or will there be negotiation?	RFQ section 2.5 states: The Apparently Successful RSNs will be expected to sign	

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		contracts with DSHS that are substantially the same as the sample contracts for the PIHP and State shown in EXHIBIT B AND EXHIBIT C. The terms of the contract are not subject to negotiation.	
140.	Can the provider authorize an intake?	See answer to question 106.	
141.	A review of individual treatment plans. Does this mean the provider or the RSN?	For utilization management requirements and questions see answer to question 108.	
142.	Is the RSN totally at risk or can this be shared by providers?	See answer to question 110.	
143.	Inpatient – Question 52 of the Handout - Who will negotiate the rates?	See the answer to question 14.	
144.	Evaluation Process - Qualifications and geographic location of evaluators. Is the process external to the MHD? I am trying to figure out who I am writing to? In terms of clinical and non-clinical.	DSHS will not release the identity of evaluators. The evaluators will be divided into 5 teams with the appropriate expertise: Fiscal/Admin Quality Program Services Information Technology Special Initiatives	
145.	If the RSN chooses to use locally developed, consensus based clinical guidelines will the RSN lose points in the scoring of the requirement?	The RSN should provide sufficient documentation to demonstrate a rigorous process in choosing the guidelines to the evaluators who will be scoring the questions.	
146.	Can the RSN establish utilization rates or can the RSN move from the traditional 75%?.	See answer to question 14.	
147.	The RSN currently needs to operate by the numbered memo, will we be able to authorize something other than 75%. Should the RSN say what the RSN would do or respond to the memo?	See answer to question 14.	
148.	Typically, many RSNs have not had independent audits. Many RSN's don't have CPAs on staff. The mental health budget is a separate budget. The State Auditors Office doesn't audit the RSN specifically. Is this sufficient?	See answer to question 22.	
149.	Does the electronic copy need to include all attachments?	See answer to question 5.	
150.	For letter of submittal will names of documents suffice for the letter of submittal?	See answer to question 95.	

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151.	For the electronic copy, how will we get all of the existing documents into the electronic version?	See answer to question 5.	
152.	(a) Is a crisis call to a crisis line a state plan service? (b) If not, then is an organization providing only this service a network CMHA as defined in this document?	(a) No. Crisis line is a direct service support cost paid partially out of Medicaid funds. (b) No, as long as the RSN is not contracting with the entity as a network CMHA. See answer to question 12.	
153.	Policies and Procedures – How will denials be tracked and reported in the template provided?	The template is in the current contract. We did not provide the template, because it is not necessary to prepare a response.	
154.	Electronic version, multiple CDs--can we do a flash drive?	CDs, DVD or a flash drive.	
155.	Inpatient – Will DSHS be responsible for all claims prior to that date?	See answer to question 14.	
156.	We don't know what our current PMPM for inpatient is?	See answer to question 14.	
157.	There is a conflict in my way of thinking between the development of inpatient level of care guidelines and the MAA MOU.	See answer to question 14.	
158.	If we write to the MAA Inpatient MOU will we get max points?	See answer to question 14.	
159.	State contract dollars – Describe the process for determining eligibility for state funded services. Is this just for ITA or past that?	See answer to question 106.	
160.	Given the number of pended answers. Is there any consideration for an extension?	The timeframes in the RFQ will remain as published.	
161.	You talk about submitting budgets do you think it would be helpful to include the total RSN budget beyond these categories? For example, other funding or grants not included in the DSHS funding. Or do you really want only these two funding sources?	Include all RSN funding sources used to fund the public mental health system in the budget submitted.	
162.	If DSHS decides to give an extension, when can we expect a decision?	See the answer to question 160.	
163.	The RSN's are asked to prepare separate budgets based on the contracts. The current funding in the state only includes the stabilization money that expires in June '06. Are we then to assume that in the funding will change? The infrastructure money only goes to June '06.	In responding to the RFQ base budgets on the funding in the September 2005 contracts.	
164.	Some RSN's have multiple binders describing internal controls. Where do RSN's draw the line on how much to submit?	Provide sufficient information for evaluators to determine internal controls are adequate.	
165.	Consumer participation requirements – We want some clarification on the inclusion in consumers in the governance. Our governing boards	RSNs must provide consumers with formal access to the governing board to provide input into the decision making	Yes

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	are commissioners who are elected.	process. 3.1.3.3. is changed to read: ~~Employ~~ Involve consumers and family members as participants in governance, administration, service delivery, and evaluation.	
166.	Should RSN's include county internal controls?	See answer to question 164.	
167.	Allied system MOUs - Molina health care has refused. How do we address this requirement when other systems refuse?	See the answer to question 122.	
168.	Draft PIHP Contract – EPSDT – goes on for 4 pages. This will create an extraordinary amount of unfunded mandates on the system. I would ask whoever wrote this to re-think this based on a 13-year-old plan seems unfounded.	The EPSDT requirements have not changed from the current contract.	
169.	Will the evaluators know whose response is being evaluated? Can the responses be blinded?	Responses will not be blinded.	
170.	PIHP – EPSDT shall authorize Level 2 requirements. Then goes on to say that Level 2 services shall be at least 10% of services offered. Not sure how this is reflective of the plan.	The PIHP contract will be changed to read as follows: 13.9.13. ~~At least 10% of the~~ Children served by two or more systems shall have Level II services authorized. 13.9.15 ~~If Level II services are authorized by the EPSDT Care Manager, the child and family~~ At least ten percent (10%) of children authorized for level two services will be referred to an Individual Service Team (IST) established for that specific child for further evaluation and development of a cross-system Comprehensive Service Plan (CSP).	Yes
171.	Frequent use of ER. We currently do not have access to information from MAA of Frequent ER use.	We acknowledge that RSN do not currently have access to ER claims data. Use the information RSNs do have available to respond.	
172.	If there can't be a deadline extension, can there be an extension for the protest?	No, the timeframes for protest will be as described in the RFQ.	
173.	State-funded services are within available resources. Will evaluators have this information?	Yes.	
174.	On page 31 of the RFQ – Allied system - what do you mean when you say a plan? Are you referring to the current process? If a plan does	The RFQ Requirement at 3.1.9.2 describes generic plan content requirements and is followed by specific requirements for	

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	not exist write a project plan that could be in place by September.	specific systems.	
175.	Some have read the RFQ and the Contract to say State hospital $ will be transferred? If the state hospital will be transferred I want to know the level of funding and how this is being determined.	There is currently no plan to transfer the state hospital funding to the RSNs.	
176.	There are times when people get into the state hospital and the state hospital won't release them when we want them released.	Acknowledged.	
177.	Can we ask that you formally respond to the receipt of questions?	A reasonable request but too late in the process to implement.	
178.	Number of copies? Can we have less?	We will modify the requirement to one original and six additional copies (7 total). See also answer to question 5.	Yes
179.	In Section 3.4.19.1," Levels of Care (LOC) Guidelines are based on published or peer reviewed standards. The RSN shall also incorporate the MHD's Access to Care Standards (4-07-03) in the guidelines, including the eligibility criteria for enrollee access to outpatient mental health services. Guidelines must include continuing stay and discharge criteria. The RSN must define the benefit period or length of stay and the intensity of service available for each treatment modality." (a) Please clarify the last sentence, "and the intensity of service available for each treatment modality". Are you expecting the LOC documents to list each treatment modality and define the intensity for each treatment modality? (b) Was this meant to state "for each level of care."?	(a) Yes. (b) No.	
180.	In the RFQ Questions and Answers document distributed on 10-19 at the bidder's conference, several questions were answered "DSHS will not answer questions that are not relevant to preparing a response" Could you please describe the process that was used to determine relevancy?	The statement cited in this question no longer appears in the answers.	
181.	Requirement 3.4.27.1 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) was written based on Exhibit J of the DSHS/MHD contract. November 2002 the RSNs received the "EPSDT Updated Plan 2002" from the Mental Health Division. The document stated it was created in response to the JLARC study and that "we are revising the plan" with this update. The RFQ requirement does not reflect this	The RFQ reflects the 2002 update.	

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	update. We are requesting a change in the requirements to reflect the update and base the response to Question 3.4.28.1.1 on that document.		
182.	On page 30, section 3.1.7.1 exists a table of Eight CORE Evidence - Based Practices. For Adults, the first box states: "Assertive Community Treatment". Should this state "Program for Assertive Community Treatment"? Or is it referring to something else?	Assertive Community Treatment and Program for Assertive Community Treatment are the same.	
183.	In the "Sample Response" included in the revised RFQ materials distributed on October 10, the format shows both questions (3.2.14.1 & 3.2.14.2) preceding the answers to both. Does the State want us to list all questions in a section (like 3.2.14) before providing answers, or will it be acceptable to have the answer follow each specific question (as in, Question 3.2.14.1, then its answer, then Question 3.2.14.2, then its answer? We would prefer the latter, particularly with sections such as 3.4.24 with multiple sub-questions.	See the answer to question 5.	
184.	Section 3.4.24.5.1 discusses "notification of the consumer of their determined level of care." Does this apply only to notifications of denials or changes to requested care, or is a notification also required for all approved levels of care? Also, if some lower levels of care such as outpatient are automatically authorized and their appropriateness reviewed retrospectively through the QAPI system, is notification of approval required for these?	RSN's are required to notify consumers of the approved level of care. In addition a written notice of action must be provided when there is a denial, reduction, termination or suspension of services. RSN's are required to notify consumers of their authorized level of care and what they are entitled to receive. The RFQ does not require that notifications of approved levels of care be in writing.	
185.	Section 3.4.23.4. The existing PIHP contract states: 1.4.18 "a) Authorization of Services - This at a minimum includes authorization for services following an intake assessment.... " In addition, the RFQ language is: 3.4.23.4 "The RSN must have a process for authorization of care following: 3.4.23.4.1. Intake Assessment... " Section #10, 10.1.1 of the proposed 2006-2007 contract only refers to RSNs having "sufficient care managers to carry out essential care management functions including:	See answer to question 106.	

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	10.1.1.1 A process for enrollees to access an intake evaluation..." Yet, the answer to question #90 on the "*RSN Procurement RFQ Questions and Answers Complete Report*" states , "The RSN must have an authorization process for intake evaluations." So, is it really the intent of the RFQ and 2006-2007 Contract that we Prior Authorize Intakes, or authorize services following an Intake assessment?		
186.	Item 3.3.2.4. reads: Provide examples of subcontract claims lag reports that demonstrate subcontractor claims, if applicable, are paid and encounters submitted within 60 days from the encounter date. Current contracts require that encounter must be submitted within 60 days of the close of each calendar month. Should 3.3.2.4. read within 60 days of the close of each calendar month?	The RFQ will be changed to read: Encounter must be submitted within 60 days of the close of the calendar month in which the encounter occurred. .	Yes
187.	It is my understanding that the purpose for including the attachments for our RFQ responses immediately following each set of questions is so that the sections can be divided among reviewers and the reviewers won't have to search for attachments. Would the following alternative be acceptable to the state: The RSNs include a separate attachment binder, clearly tabbed with attachment numbers so that reviewers can easily locate the attachments by number. The RSNs could include enough copies of this attachment binder so that each reviewer has their own copy. This means that each reviewer would have a complete set of all attachments, but that they could easily locate the attachment they need to review by the numbered tab in the binder. This would greatly simplify the production process for the RSNs.	The alternative is acceptable. If an RSN chooses the stated alternative, labeling and references must be clear and understandable to evaluators. The RSN is required to submit twenty (20) copies of the attachment set if an RSN chooses the alternative format for attachment submission.	
188.	In formatting the pages do you want responses only on one side or can they be on both sides of the paper?	Responses may be double-sided.	
189.	Section 2.12 Response Submission Format This section describes the requirements for paper size and font size; however, there is not a description regarding margin width or if the RFQ response may be double-sided copy. Please clarify the Procurement Team expectations for margin width and if the response may be double-sided copy?	There is no margin width requirement. The response may be double-sided. It is in the RSNs' best interest to present materials in a manner that allows evaluators to read and find materials easily.	
190.	Section 2.4 Acceptance of RFQ Terms	We suggest that RSNs consult with legal counsel to understand	

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	This section states that a response submitted in response to this RFQ shall be considered a binding offer. What is meant by "response to this RFQ shall be considered a binding offer"?	the meaning of a "binding offer."	
191.	Section 2.19 Evaluation, Scoring and Criteria Subsection, 2.19.3. Mandatory Scored Requirements and 2.19.3 Mandatory Scored Requirements. The second paragraph in each of these subsections states that "A score of 0 is grounds for disqualification for any of the following conditions" and then lists five conditions. Condition 2.19.2.5 and 2.19.3.5 states "DSHS determines in any manner" that a RSN is unable or unwilling to comply… Please clarify what is meant by the phrase "determines in any manner".	The RFQ is amended to remove the words "in any manner" from sections 2.19.2.5 and 2.19.3.5	Yes
192.	Subsection 2.19.5 Evaluation Teams states that … "staff involved in RFQ development .. may develop information for presentation to the teams". What types of information? Will the RSNs be consulted prior to the presentation of information about RSNs by the "staff"?	The information developed, if any, would be training materials addressing the Requirements of the RFQ. DSHS does not contemplate developing information specific to any RSN. RSNs will not be consulted regarding any information presented to evaluators.	
193.	Section 3.2 Administrative and Financial Requirements Subsection 3.2.1, question 3.2.1.5 requires "a list of all RFQ amendments downloaded by the RSN from DSHS Procurements Website, if applicable, and listed in order by amendment number and date;…". It is unclear what should be included in the letter of submittal. Please clarify if the letter of submittal should incorporate the complete amendment or only the number and date? An amendment to the RFQ was e-mailed to RSNs; however, it does	RSNs must list in the Letter of Submittal, only the single amendment named and dated: "November 2, 2005 Amendment". RSN's are not required to separately list each amendment incorporated in these questions and answers. All final questions and answers and amendments will be published on the website. The first amendment was sent to RSN's in draft form to alert them to an important change to the RFQ. The final amendment is included with these questions and answers.	

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	not appear to be posted on the MHD Procurement Website? Is the e-mailed amendment an "official" amendment, or should it be downloaded, when available, from the procurement Website? OR Is there a different location other than the Mental Health Division's website where the RFQ amendments can be found?	Amendment contents need not be included in the Letter of Submittal.	
194.	Section 3.3 Information System Requirements Subsection 3.3.2 Encounter Data, question 3.3.2.2 requests RSNs to "Provide copies of submission reports that are generated during encounter submission process, both from subcontractors to the RSN and from the RSN to MHD." Can this include reports received from MHD after receipt of the RSN submission of data and RSN reports to subcontractors after receipt of subcontractor submission of data?	Yes	
195.	3.2.15 reads that "The RSN shall ensure a process is in place to demonstrate that all third-party resources are identified, pursued, and recorded in accordance with Medicaid being the payer of last resort. All funds recovered by the RSN from third-party resources shall be treated as income and will be used to support the public MH system." Since our contracted provider agencies do business with other entities such as EAPs, MCOs, etc. should this section be interpreted to mean only third party payments received directly by the RSN and not our contracted provider agencies?	This section refers to all third party resources used to support the public mental health system regardless of whether the resource is identified at the provider or RSN level.	
196.	The email dated 9/29 stated that all RFQ documents would be posted to the web site: http://www1.dshs.wa.gov/Mentalhealth/RSN_Procurement.shtml No answers to questions have been posted there since July. Are the answers that were handed out at the bidders conference final answers, will they be posted to the web site, and will answers to all pending	See answer to question 111. Yes all answers will be posted.	

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	questions be posted there?		
197.	3.3.1.4. The RFQ requires the RSN to send data to MHD within 60 days of the end of the month of service (3.3.1.4.). It also requires providers to pursue all third party reimbursement (3.2.15.). However under normal coordination of benefits, described by Dale Jarvis, providers bill and collect from third party payers in a defined sequential order. In some moderate number of cases it may take longer than 60 days to determine what charges, if any, remain to be paid by the PHIP. The RFQ seems to assume that the RSN will pay the provider a negotiated fee for the service and that all recovery from third parties would be treated as income to the RSN. What is the assumption of MHD on how third party recovery should work? If it is normal COB how can the RSN commit to sending data within 60 days when it may take more than 60 days to pursue all third party sources?	3.3.1.4. refers to encounter data reporting not to third party revenue reporting. The RFQ does not assume that the RSN will pay providers fee for service. See RFQ section 3.2.16. for the questions that require a response regarding Third Party Liability.	